

**Indiana Enhanced Influenza Surveillance Program  
Enrollment Form**

**Name of Health Care Facility:** \_\_\_\_\_

**Facility Type:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Student Health |
| <input type="checkbox"/> Family Practice    | <input type="checkbox"/> OB/GYN            | <input type="checkbox"/> Urgent Care    |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Pediatrician      | <input type="checkbox"/> Other          |

**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_

**Physical Address:** \_\_\_\_\_

\_\_\_\_\_

**County of Practice:** \_\_\_\_\_

**Facility Phone #:** (      ) \_\_\_\_\_

**Facility FAX #:** (      ) \_\_\_\_\_

**Primary Contact Person:** \_\_\_\_\_

**Primary Contact Person Phone #:** \_\_\_\_\_

**Primary Contact Email address:** \_\_\_\_\_

**Additional Contact Person:** \_\_\_\_\_

*Please FAX completed form to the Epidemiology Resource Center: 317-234-2812*